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Medical Facilities Survey
and
Plan

1954 - 1955

Maryland State Planning Commission
April 1956

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1954 - 1955

Prepared by the

Survey Committee on Medical Facilities

of the

COMMITTEE ON MEDICAL CARE

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April 16, 1956

Hon. Theodore R. McKeldin
Governor of Maryland
Annapolis, Maryland

Dear Governor McKeldin:

I take great pleasure in transmitting herewith, for your consideration and review, the report entitled "Medical Facilities Survey and Plan, 1954—1955."

The Survey Committee on Medical Facilities, functioning as part of the Committee on Medical Care, has completed its study, which was undertaken at the request of the State Board of Health through the Maryland State Planning Commission.

The Plan was submitted to the State Board of Health, after which it was adopted upon recommendation of its Advisory Council on Hospital Construction, and as required under the provisions of the Wolverton Amendment of the Hill-Burton Program, a public hearing was held on March 27, 1956.

The Plan was subsequently submitted to the Surgeon General of the U. S. Public Health Service, and approval was received by the State Board of Health on April 11, 1956.

In behalf of the Commission, I should like to make grateful acknowledgment of the valuable services rendered by the members of the Committee on Medical Care, and Dr. James T. Marsh, Chairman and the members of the Survey Committee, who contributed so generously of their time and effort to this important study.

I also wish to take this opportunity to express the Commission's gratitude to you for your continued interest and support of its programs.

Very sincerely yours,

James C. Alban

James C. Alban, *Chairman*

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I. ALVIN PASAREW
Director

March 12, 1956

Dr. Perry F. Prather, Director
State Department of Health
2411 N. Charles Street
Baltimore 18, Maryland
Dear Dr. Prather:

We are pleased to send you herewith the "Medical Facilities Survey and Plan, 1954-1955," which was prepared under the auspices of the Commission's Committee on Medical Care.

The study was undertaken at the request of Dr. Robert H. Riley, former Director of the State Department of Health, under the Wolverton Amendment to the Hill-Burton Program.

The report of the Subcommittee, which was headed by Dr. James T. Marsh, has been approved by the Committee on Medical Care. At the request of the Committee's Chairman, Dr. George H. Yeager, we are forwarding the report for your review and release.

The Commission sincerely trusts that the findings and recommendations transmitted may prove of value to the State Department of Health.

With kind personal regards, I am

Sincerely yours,

James C. Alban

James C. Alban, *Chairman*

MARYLAND STATE PLANNING COMMISSION

COMMITTEE ON MEDICAL CARE
GEORGE H. YEAGER, M. D.
Chairman

1211 Cathedral Street
Baltimore 1, Maryland

March 9, 1956

Dear Mr. Alban:

The report of the Survey Committee on Medical Facilities, "Medical Facilities Survey and Plan, 1954-1955," is submitted herewith.

The Federal Survey and Construction Act, Public Law 725, 79th Congress (Hill-Burton Program) was amended by the 83rd Congress, which enacted Public Law 482 (Wolverton Amendment) Appendix A, which authorized the appropriation of Federal funds on a categorical basis for construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation centers, and nursing homes. The law requires that a State, in order to be eligible for its share of the Federal appropriation, make a survey of all existing facilities in the four categories, determine the unmet need in each, and prepare a Plan for the construction of the needed facilities.

From the licensing records of the State Department of Health, an inventory of nursing homes and chronic disease hospitals and their bed capacities was obtained. A field survey was made of the diagnostic and treatment facilities throughout the State by the staff of the Committee on Medical Care. The staff of the Division of Vocational Rehabilitation of the State Department of Education made a State-wide field survey of rehabilitation facilities. On these bases the Plan for the construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation centers, and nursing homes was prepared.

It is felt that the Plan fully complies with all Federal requirements and is in such form that it should receive the approval of the Surgeon General. Approval by the Surgeon General will qualify for aid from Federal funds for the construction of the needed facilities.

During this survey, we have had the assistance and cooperation of various State and private agencies. This assistance has been of great value and is appreciated.

Very sincerely yours,

George H. Yeager, M.D.

George H. Yeager, M.D., *Chairman*

Mr. James C. Alban, Chairman
Maryland State Planning Commission
100 Equitable Building
Baltimore 2, Maryland

MARYLAND STATE PLANNING COMMISSION

COMMITTEE ON MEDICAL CARE
GEORGE H. YEAGER, M. D.
Chairmon

1211 Cathedral Street
Baltimore 1, Moryland

March 9, 1956

Dear Dr. Yeager:

The report of the Survey Committee on Medical Facilities, including the Survey and Plan for development of Chronic Disease Hospitals, Nursing Homes, Diagnostic and Treatment Centers, and Rehabilitation Centers, is submitted herewith. The Plan was prepared in line with regulations and instructions promulgated by the Public Health Service under the Wolverton Amendment to the Hill-Burton Hospital Construction Program, and is in such form that it should receive the approval of the Surgeon General.

Through the period of the work of making the survey and preparing the plans for the several categories of facilities, the Committee had the assistance and cooperation of the staff of the State Department of Education, Division of Vocational Rehabilitation, and the Department of Health, Division of Hospital Services. The work was impeded on account of the recall of our Survey Director, Dr. John H. Janney, by the Rockefeller Foundation.

It is the recommendation of this Committee that the accompanying report be approved by the Committee on Medical Care and transmitted through the State Planning Commission to the State Department of Health for administration.

Respectfully yours,

James T. Marsh

James T. Marsh, M.D., *Chairman*
Survey Committee on Medical Facilities

Dr. George H. Yeager, Chairman
Committee on Medical Care
1211 Cathedral Street
Baltimore 1, Maryland

TABLE OF CONTENTS

Page

FOREWORD xvii

CHAPTER I

INTRODUCTION 1

Care of the Chronically Ill 1

CHAPTER II

FEDERAL REQUIREMENTS 3

CHAPTER III

NURSING HOMES 4

Definition 4

Inventory and Classification 5

Ratio of Nursing Home Beds to Population 5

Nursing Home Service Areas 6

Page

CHAPTER IV

CHRONIC DISEASE HOSPITALS 11

Facilities for Chronically Ill in Maryland 11

Recommended Plan for Construction 11

CHAPTER V

REHABILITATION CENTERS 14

Inventory of Existing Facilities 14

Program of Distribution and Priority 14

CHAPTER VI

DIAGNOSTIC AND TREATMENT CENTERS 20

Definition 20

Origin and Function of Diagnostic and Treatment Centers 20

Federal Participation 20

Inventory 20

LIST OF TABLES

Page

TABLE 1. Inventory of Nursing Homes (Condensed) 6

TABLE 2. Inventory of Nursing Homes (Detailed) 7-8

TABLE 3. Nursing Home Summary 9

TABLE 4. Priority Listing of Nursing Home Areas 10

TABLE 5. Acceptable and Non-Acceptable Chronic Disease Hospitals 13

Page

TABLE 6. Inventory of Rehabilitation Facilities 16-17-18

TABLE 7. Rehabilitation Facilities Summary 19

TABLE 8. Diagnostic and Treatment Centers Summary 21

TABLE 9. Inventory of Diagnostic and Treatment Centers 22-23

TABLE 10. Diagnostic and Treatment Facilities—Relative Need Report 24

FOREWORD

The Federal Survey and Construction Act, Public Law 725, 79th Congress (Hill-Burton Program) was amended by the 83rd Congress, which enacted Public Law 482 (Wolverton Amendment) Appendix A, which authorized the appropriation of Federal funds on a categorical basis for construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation centers, and nursing homes. The law requires that a State, in order to be eligible for its share of the Federal appropriation, make a survey of all existing facilities in the four categories, determine the unmet need in each, and prepare a Plan for the construction of the needed facilities.

The Amendment specifies that the Survey and Plan are the responsibility of the agency which was designated as the "sole agency" to administer the Hospital Construction Program under the original act. In Maryland, as in most other states, this is the State Department of Health.

Under the original law, the Committee on Medical Care of the State Planning Commission set up a subcommittee known as the Hospital Survey Committee and charged it with making a survey and plan as required by law. While this work was in progress, the Legislature enacted a law which designated the State Department of Health as the sole agency for the administration of the program in Maryland.

The State Board of Health, when considering the procedure under which the State would make itself eligible under the Wolverton Amendment, decided that the Survey and Plan should be prepared by some group other than the one responsible for its administration. Because of the satisfactory manner in which the original Survey and Plan were completed by the State Planning Commission, the Board took action requesting the Maryland State Planning Commission, through its Committee on Medical Care, to make a survey and prepare a plan in the four categories under the Wolverton Amendment. The State Planning Commission accepted the request and delegated the work to its Committee on Medical Care. A subcommittee, known as the Survey Committee on Medical Facilities, was appointed, with Dr. James T. Marsh as Chairman.

From the licensing records of the State Department of Health, an inventory of nursing homes and chronic disease hospitals and their bed capacities was obtained. A field survey was made of the diagnostic and treatment facilities throughout the State by the staff of the Committee on Medical Care. The staff of the Bureau of Vocational Rehabilitation of the State Department of Education made a State-wide field survey of rehabilitation facilities. On these bases the Plan for the construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation centers, and nursing homes was prepared.

The Plan was submitted to the Committee on Medical Care, which approved and transmitted it to the State Planning Commission. The State Planning Commission, in turn, reviewed and approved the Plan and forwarded it to the State Department of Health in fulfillment of its request.

The State Board of Health, upon receipt of the Plan from the State Planning Commission, referred it to its Advisory Council on Hospital Construction for review and a recommendation.

The Council reviewed the Plan in detail, after which it returned it to the State Board of Health with a recommendation for adoption.

The Plan was adopted by the State Board of Health and submitted for public review at a hearing held in Bennett Hall, 20 E. 23rd Street, Baltimore, on March 27, 1956. Notice of the hearing previously had been given to all newspapers in Maryland and to all institutions listed in the several inventories. The State Department of Public Welfare and all local Welfare and Health departments also were given notice for posting or publication.

The Plan was subsequently submitted to the Surgeon General, U. S. Public Health Service for review and approval. Approval was received April 11, 1956.

CHAPTER I

INTRODUCTION

The care of the chronically ill and disabled, which has always been a difficult social problem, has until recently been handled largely by families or charitable organizations, with local governments providing for some of the destitute. In the past twenty years, the problem has reached such magnitude that these limited facilities have proved unable to cope with the demands and it has become necessary for Federal, State, and local governments to assume a share of the burden and develop public facilities for the care of these people.

Because of their diagnostic facilities and their medical staffs, including specialists in many fields, general hospitals are the most satisfactory hospitals for the initial institutional care of patients having conditions indicating a long-term of illness. Because of the high cost of general hospital services and the present shortage of general hospital beds, the admission of cases requiring long term care have a low priority. Only when general hospitals are able to attach facilities specifically provided for the patients needing prolonged medical care, or develop a close affiliation with a chronic disease hospital, will they play a larger role in meeting the need of hospitalization for chronically ill patients.

Advances in medical diagnosis and new methods in treatment have reduced the duration of illness and improved the rate of recovery, thus extending life expectancy. New limits attained in this country were undreamed of fifty years ago. Lengthening of the life span during the first half of the century resulted chiefly from a reduction in infant mortality. Since 1935 mortality rates in the older ages have also evidenced significant decline. Each year, as a result, the proportion of the population over age 65 is increasing. It is sufficient to say that since the incidence of chronic disability increases sharply with age, the problem of caring for the chronically ill will increase along with the number of citizens who live beyond the age of 65.

After World War II, it became evident that facilities for the care of the chronically disabled and the methods for financing such care were totally inadequate and a new approach to the problem was urgently required.

At the Federal level, the (Hill-Burton) Hospital Construction Program was amended to provide funds as grants toward the construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation centers, and nursing homes. National organizations, such as the Commission on Chronic Illness, have undertaken studies of the problem. State and local groups across the nation have the subject under study. Interest in the problem is now approaching the proportions of the problem itself.

This Survey and Plan is intended to qualify Maryland for the use of Federal funds appropriated to assist in the construction of facilities in the four categories.

Care of the Chronically Ill

According to modern concepts, the chronically ill patient may receive medical care in the following types of institutions:

A. General Hospitals
Providing all types of medical care. Available to all economic groups of the population.

B. Chronic Disease Hospitals
Providing evaluation, internal medicine, physical medicine, rehabilitation. Beds in chronic disease hospitals operated by the State of Maryland are available only to patients who have less than $180 a month to pay for the care.

C. Nursing Homes
Providing nursing care under medical supervision. Available to all economic classes, but for the most part used by those who are able to pay for the reason that people in low income brackets generally cannot afford the purchase of such care. The maximum welfare grant to indigents by the State Department of Welfare standards is $90 per month, of which $87.50 may be used for the purchase of care in a nursing home.

If a resident of Maryland who is indigent or medically indigent becomes ill and needs hospitalization, he would normally be expected to go into a general hospital where the State will pay toward the cost of his care at the rate of $12 a day. This payment is supplemented by Baltimore City and the counties within the limits of cost. If it is found that his condition is such as to require treatment over an extended period of time, theoretically he will, in due course, be transferred to a State or Baltimore City chronic disease hospital, his admission depending on:

1. Availability of bed
2. The type of medical care needed
3. The patient's progress and potential of rehabilitation; prognosis

In the chronic disease hospital, the patient will be evaluated and classified according to his recovery potential. The patient whose potential is good will then be given rehabilitative treatment, aimed at eventually improving his physical condition to the point that he may return to his home, or, if convalescence should be prolonged and social conditions for his care at home be unfavorable, he may be sent to a nursing home.

If his recovery potential is poor or nil, or if he is a terminal case or a case which will need long continued bed care, he may be transferred to a nursing home, but if incompatible with such environment, may be placed in an infirmary type of service in a State chronic hospital.

Evaluation in a general hospital may indicate direct transfer to the nursing home. It is also possible

that long-term patients may be admitted to either the chronic hospital or the nursing home directly from their own homes.

In any program for the chronically disabled, it is essential that there be maintained a flow of patients from more expensive general hospitals, offering all types of specialties, to hospitals devoted chiefly to the care of the chronic patient and cheaper to operate, or to a nursing home which offers primarily nursing care, or to their own or foster home. One of the first essentials is that there are ample facilities available at each level to maintain this flow in both directions.

This survey is concerned with each of the essential facilities which are directly related to the care of the chronically ill and disabled:

1. Hospital Facilities for Chronically Ill
2. Rehabilitation Centers
3. Nursing Homes
4. Diagnostic and Treatment Centers

The above discussion is pointed toward the need of the first three facilities cited to serve the chronically ill. It is obvious, however, that the services of the Diagnostic and Treatment Centers will be available also to patients with short-term illness or diagnostic problems.

In the following pages each of these categories will be described as it exists in Maryland. State needs in each category will be shown and a plan for the construction and operation presented.

CHAPTER II

FEDERAL REQUIREMENTS

The Law and Federal Regulation established basic requirements relating to classification of existing facilities, sponsors, and assurances required of applicants.

Survey:

For the purpose of establishing the unmet need for facilities in the four categories, a State-wide inventory must be made of all existing facilities.

Determine need:

The need for additional facilities must be established on the basis of the differential between the existing facilities and the determined need.

Priorities:

A schedule of priorities must be established giving highest priority to areas of greatest unmet need.

Eligible applicants:

1. The State, or political subdivision
2. A public agency
3. A nonprofit corporation or association, the nonprofit status being established by tax exemption, or by articles of incorporation, charters, or bylaws.

Population served:

The sponsor must be committed to offering a community service. A facility renders a community service when the services provided in the facility are available to the general public in accordance with these regulations. Even though its services are limited to individuals selected on the basis of the type and kind of medical care needed, the service may be considered as community-wide in scope. A service limited by financial status, or by race, creed, color, etc. is, on the other hand, not so considered.

Services:

Patients must be under the professional supervision of persons licensed to practice medicine or surgery in the State, or dentistry, as applicable.

Transfer of funds between categories:

In the absence of eligible applicants in one of the categories of Chronic Disease Hospitals, Diagnostic and Treatment Centers, or Nursing Homes, funds may be allocated to projects in another category, however, no funds may be transferred into or out of the category of Rehabilitation.

Population estimates:

The needs in the several categories are calculated in the original Plan on the most recent estimates by the Bureau of Census. The population estimate used in this report, viz. 2,522,000, was furnished in "Current Population Reports" by the Bureau of Census, Series P-25, No. 104. From this figure the Division of Vital Records and Statistics of the State Department of Health, provided the breakdown by counties.

CHAPTER III

NURSING HOMES

The importance of the nursing home as a facility for the care of the chronically ill is obvious today. Basically, it is a facility serving a large proportion of chronically ill people whose needs are primarily nursing care. It has been developed to take care of patients who are partially or totally disabled, who do not need highly specialized continuous medical care, but who do need skilled nursing service round-the-clock.

Some progress has been made in providing chronic disease hospital facilities in Maryland. In the inventory of chronic disease hospitals (Chapter IV), 12 institutions are recorded with a total bed capacity of 2,152. The inventory includes 409 beds which are in the process of construction which reduce the number now available to 1,743. The State, under its Chronic Disease Hospital Program, has provided chronic disease hospital care but does not at this time propose the construction of nursing home facilities. Some nonprofit organizations have provided nursing home facilities, although the majority of such beds are located in proprietary nursing homes.

The Wolverton Amendment to the Hill-Burton Act recognizes the importance of nursing homes in relation to the treatment of the chronically ill in bringing about a more efficient use of the beds in the general hospitals and in the chronic hospitals. This Amendment authorizes Congress to appropriate funds for the construction of nonprofit nursing homes on a matching basis. Since available funds are limited, priorities among the different nursing home service areas are set up as a part of this Plan.

Definition

A nursing home is defined by the Public Health Service as:

> A facility which is operated in connection with a hospital, or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery within the State, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who do require skilled nursing care and related medical services. The term 'nursing home' shall be restricted to those facilities, the purpose of which is to provide skilled nursing care and related medical services for a period of not less than 24 hours per day to individuals admitted because of illness, disease, or physical or mental infirmity and which provide community service.

In 1940 a survey was made of almshouses in Maryland for the purpose of determining the needs of the inmates and projecting a plan for their proper care. The survey disclosed that many of these inmates were chronically ill. Some were recommended for transfer to mental or tuberculosis hospitals and others were thought suitable patients for projected chronic disease hospitals. The report referred to boarding houses and infirmary units for the frail aged but did not mention the nursing home.

In 1945 the General Assembly enacted a law requiring a license for the operation of any hospital within the State. A hospital was defined as *any institution which maintains and operates facilities for the care and/or treatment of two or more nonrelated persons as patients suffering mental or physical ailments.* Under this law, the State Department of Health set up two sets of regulations: one for general and special hospitals, and the other for nursing, convalescent, and care homes.

For the purposes of the Licensing Program, homes for chronic and convalescent patients, including nursing and convalescent homes and homes for the aged, are so classified if they are *providing chronic and convalescent care.* Chronic and convalescent care is defined to include *care given to a person because of prolonged illness or defect, or during recovery from an injury or disease, and includes any or all of the procedures commonly employed in waiting on the sick, such as administration of medicines, preparation of special diets, giving of bedside care, application of dressings and bandages, and carrying out of treatments prescribed by a licensed physician.* Care homes are defined as those *which provide board, shelter, and personal services in a protective environment for persons not gainfully employed.* Under the definitions quoted above, it is apparent that certain institutions which are known by other titles fall into the category of nursing homes.

The initial survey of nursing, convalescent, and care homes under the State licensing law was conducted in 1946 and 1947, concurrent and in cooperation with the survey of all medical facilities in the State under the Hill-Burton Program. At that time it was found that 114 such institutions were being operated in the State. As of June 30, 1955, there were recorded in the Health Department 182 nursing, convalescent and care homes, with a total capacity of 5,394 beds. An analysis of these beds shows that 3,242 should be classified as nursing home beds, according to the Public Health Service definitions quoted above. Beds planned at Baltimore City Hospitals totaling 250 were added, bringing the total to 3,492. The differential of 2,152 beds were not classified as nursing home beds for the reason that they were located in care homes, or sections of institutions which provided only domiciliary care.

The terms *nursing service, chronic illness,* and *disability* are quite unspecific as compared with *fracture, acute appendicitis,* and other acute conditions, or mental illness, or tuberculosis. Because of this vagueness of definition in the case of chronic illness and disability, the category of institutions known as nursing homes may be found to have, as patients, persons with conditions ranging from advanced incurable cancer, incontinence, and other severe physical conditions, to those who are merely feeble because of advanced age. Under the current survey, therefore, the total number of beds main-

tained in nursing and convalescent homes and other institutions meeting the Federal definition of a nursing home, were taken into account. They were considered as meeting a demand for service of varying degrees by patients whose needs could not be met in private homes.

Inventory and Classification

A field survey was considered unnecessary for the reason that the State Department of Health, under its inspection and licensing program, was able to supply records from which the institutions could be classified and the beds tabulated. Tables 1 and 2 list the nursing homes by county and classify the beds in each as *Suitable, Replaceable,* or *Unsuitable.* Institutions which were classified as *Unsuitable* are not identified.

For the purposes of this Survey and Plan, the fact that a nursing home was licensed by the State was not considered tantamount to being a suitable institution. Under the State's standards, the converted dwellings in which most nursing homes are located have been made reasonably safe and provide a reasonable amount of nursing service. When considering them from the point of view of a construction program, however, most of them were not of the structural type nor design which would be built under modern standards with adequate funds available. For the purpose of classifying the nursing home facilities as suitable, replaceable, and unsuitable, the committee set up the following criteria:

1. **Suitable Nursing Home**
   An institution which meets the official definition of a nursing home and which is operated in a structure built or remodeled as a hospital or nursing home, and meeting State Health Department licensing standards of safety and equipment. This category is suitable for permanent use. It is eligible for remodeling and/or expansion, but is not eligible for a replacement project.
2. **Replaceable Nursing Home**
   An institution which meets the official definition of a nursing home and which is operated in a structure which falls short of licensing standards in one or more respects, and economically cannot be made to conform therewith.

   Examples:

   (a) Multistoried buildings, even though fire-resistive, which because of design cannot economically be made to comply with State licensing standards

   (b) Frame buildings (or ordinary construction), even though provided with an approved sprinkler system.
3. **Unsuitable Nursing Home**
   An institution which fails to qualify as either suitable or replaceable under paragraphs 1 and 2 above, because it is so limited as to structure and design and other features that there is no prospect of its ever attaining satisfactory minimum standards and should be abandoned as soon as possible.

   Examples:

   (a) Multistoried frame buildings, even though provided with sprinklers

   (b) Halls and/or stairs too narrow for convenient transportation of patients

   (c) Remote from fire company (5 miles or more)

   (d) Inadequate sewage system and/or water supply

   (e) Access roads impassable at times

Beds in the same institution in some cases were divided between classifications. This occurred in situations where a modern addition, designed and built for use as a nursing home, has been added to a replaceable facility. Under such circumstances, the beds in the new structure were classified as suitable and those in the old structure as replaceable.

At the time of the inventory, there were 1.073 beds which qualified as nursing home beds in Baltimore City, of which 331 were classified as suitable or replaceable. For planning purposes 250 additional beds planned for the Infirmary at Baltimore City Hospitals were added to the inventory in Tables 1 and 2. In the counties, out of a total of 2,169 nursing home beds, 513 were classified as suitable or replaceable beds. Of the 102 nursing homes in the counties, 19 have suitable or replaceable beds. Sixteen counties have no suitable or replaceable nursing home beds within their borders, as shown in Table 3.

Ratio of Nursing Home Beds to Population

Out of a total of 5,394 beds included under the State Licensing Program, 3,492 were classified as nursing home beds as defined by the Public Health Service. Those not so classified are in care homes or homes for the aged, which are licensed because they maintain an infirmary for their guests who become ill. While most of the beds in licensed homes of all categories are in unsuitable structures, this total number of beds maintained in the State is considered by the Committee as indicative of the demand for such facilities.

The argument may be advanced that the census of nursing home patients is not a true indication of the needs of the State for this facility. The rehabilitation program which is just getting under way in the chronic hospitals should eventually make its effect felt, by making it possible for patients who are now bedridden or who require considerable service, to return to their homes or be kept in a nursing home facility. Had a rehabilitation program been in effect in the past, it is felt that a number of people who are now in chronic hospitals and nursing homes would not be there. However, this maintenance of a flow of patients would have resulted in a greater number passing through the beds and perhaps little decrease in the number now being cared for in these facilities. The number would remain practically the same, but

the proportion of those who have reached the limit of their potential rehabilitation would be greatly increased.

The State now has in use 436 beds in its chronic hospitals, which number will be increased to 1,100 beds within the next decade. Since the State is only midway in its program for the construction of chronic hospital beds, it was felt that with the aid of the rehabilitative program now in operation and planned in State chronic hospitals, many patients now in nursing homes might be rehabilitated to a degree of self-help which would permit their transfer to private or foster homes.

It was concluded that it would be unsafe to set a quota at less than today's demands because of the increasing number and proportion of the population in the upper age group. It is also true that there probably exists a considerable group falling in the borderline economic class between indigent and those able to pay full rates. In addition, it is known that there is also a group which is being cared for in some type of facility which falls short of meeting their needs.

The 3,492 existing and planned nursing home beds represent a ratio of approximately 1.38 beds per thousand population. In view of these considerations, the standard ratio of nursing home beds for Maryland was established at 1.5 beds per thousand population. On the basis of 2,522.000 population, this would establish the need at 3,783. When this figure is reduced by the 1,094 beds classified as acceptable or replaceable, the unmet need is established at 2,689 nursing home beds. See Table 3.

Nursing Home Service Areas

The generally accepted concept is that nursing homes should be small units with a capacity between 25 and 75 beds, and that they should be community facilities so located as not to remove the patient too far from family and residence. Nursing homes operating at a higher professional level and in conjunction with the chronic hospitals, have taken over the problem of caring for the chronically ill, many of whom formerly were handled by the almshouses. Since the care of the chronically ill below the level of hospitals is considered largely a local problem, it is concluded that the nursing home program under the Wolverton Act should be planned at the county or city level.

Therefore, in this plan 23 service areas are delineated. Each county is defined as a service area with the exception of Baltimore County which, along with Baltimore City, is considered as a single area because of the integration in many phases of their medical care programs. The other 22 areas will conform to county boundaries. This does not preclude the possibility of two or more areas jointly sponsoring a project. Table 3 provides estimates of the total number of beds needed for each of these areas at the rate of 1.5 beds per thousand population, the existing beds, and the quota of unmet needs for each.

In Table 4, the areas have been arranged in order of unmet needs, expressed as beds per thousand population. This is the order of priorities for Federal aid.

Table 1

INVENTORY OF NURSING HOMES
(Condensed)

June 30, 1955

Name of Facility	Areas	Ownership or Control	Bed Capacity			Occupancy On Jan. 20, 1955	Annual Admissions
			Suitable	Replaceable	Unsuitable		
2 Nursing Homes	Allegany		—	—	14	14	26
4 " "	Anne Arundel		—	43	51	88	90
60 " "	Baltimore City—County		340	241	1,218	1,645	2,983
1 " "	Calvert		—	—	20	16	27
— " "	Caroline		—	—	—	—	—
6 " "	Carroll		26	—	85	90	84
3 " "	Cecil		—	—	31	27	41
1 " "	Charles		—	—	8	6	267
1 " "	Dorchester		—	—	15	26	15
5 " "	Frederick		10	16	27	56	45
4 " "	Garrett		—	—	99	96	61
1 " "	Harford		—	—	37	28	14
2 " "	Howard		—	—	72	73	122
1 " "	Kent		—	—	5	4	8
30 " "	Montgomery		68	25	469	408	571
5 " "	Prince George's		7	—	47	41	69
— " "	Queen Anne's		—	—	—	—	—
— " "	Somerset		—	—	—	—	—
— " "	St. Mary's		—	—	—	—	—
— " "	Talbot		—	—	—	—	—
7 " "	Washington		28	40	115	201	195
4 " "	Wicomico		—	—	80	59	61
1 " "	Worcester		—	—	5	5	11
138 Nursing Homes			479	365	2,398	2,883	4,690

Table 2

INVENTORY OF NURSING HOMES
(Detailed)

June 30, 1955

NAME OF FACILITY	AREAS	OWNERSHIP OR CONTROL	BED CAPACITY			OCCUPANCY ON JAN. 20, 1955	ANNUAL ADMISSIONS
			Suitable	Replaceable	Unsuitable		
2 Nursing Homes	Allegany	Prop.	—	—	14	14	26
			—	—	14	14	26
4 Nursing Homes	Anne Arundel	Prop.	—	43	51	88	90
			—	43	51	88	90
Aged Men's and Aged Women's Homes	Baltimore City	NPA	32	—	—	21	72
Anderson Rest and Conv. Home	Baltimore City	Prop.	15	—	24	33	47
General German Aged Peoples Home of Baltimore	Baltimore City	NPA	12	—	—	83	5
Home for Aged of Methodist Church	Baltimore City	NPA	30	—	—	20	128
Mt. Sinai Home	Baltimore City	Prop.	40	—	17	56	50
27 Nursing Homes	Baltimore City	Prop.	—	202	644	777	1,338
2 Nursing Homes	Baltimore City	NPA	—	—	57	50	191
			129	202	742	1,040	1,831
Armacost Nursing Home	Baltimore	Prop.	16	—	24	40	118
College Manor	Baltimore	Prop.	85	23	—	72	66
House in the Pines	Baltimore	Prop.	13	—	51	63	92
Masonic Home	Baltimore	NPA	55	—	—	53	146
Stella Maris Hospice	Baltimore	Church	42	—	—	34	61
17 Nursing Homes	Baltimore	Prop.	—	12	372	311	631
3 Nursing Homes	Baltimore	Church	—	4	29	32	38
			211	39	476	605	1,152
1 Nursing Home	Calvert	County	—	—	20	16	27
			—	—	20	16	27
Long View Nursing Home	Carroll	Prop.	26	—	12	34	28
5 Nursing Homes	Carroll	Prop.	—	—	73	56	56
			26	—	85	90	84
3 Nursing Homes	Cecil	Prop.	—	—	31	27	41
			—	—	31	27	41
1 Nursing Home	Charles	Prop.	—	—	8	6	267
			—	—	8	6	267
1 Nursing Home	Dorchester	Prop.	—	—	15	26	15
			—	—	15	26	15

NPA—Non-Profit Association.
Prop.—Proprietary.

Table 2 (Continued)

INVENTORY OF NURSING HOMES
(Detailed

June 30, 1955

NAME OF FACILITY	AREAS	OWNERSHIP OR CONTROL	BED CAPACITY			OCCUPANCY ON JAN. 20, 1955	ANNUAL ADMISSIONS
			Suitable	Replaceable	Unsuitable		
Md. Odd Fellows Home	Frederick	NPA	10	—	—	4	1
2 Nursing Homes	Frederick	Prop.	—	9	15	15	22
1 Nursing Home	Frederick	City	—	7	—	29	—
1 Nursing Home	Frederick	County	—	—	12	8	22
			10	16	27	56	45
4 Nursing Homes	Garrett	Prop.	—	—	99	96	61
			—	—	99	96	61
1 Nursing Home	Harford	Prop.	—	—	37	28	14
			—	—	37	28	14
2 Nursing Homes	Howard	Prop.	—	—	72	73	122
			—	—	72	73	122
1 Nursing Home	Kent	Prop.	—	—	5	4	8
			—	—	5	4	8
Asbury Home of Methodist Church	Montgomery	Church	39	—	—	20	52
Kensington Gardens	Montgomery	Prop.	15	—	17	25	38
Waverly Sanatorium	Montgomery	Prop.	14	—	25	33	40
26 Nursing Homes	Montgomery	Prop.	—	25	389	304	390
1 Nursing Home	Montgomery	NPA	—	—	38	26	51
			68	25	469	408	571
Sacorda Rest Home	Prince George's	Prop.	7	—	4	9	10
4 Nursing Homes	Prince George's	Prop.	—	—	43	32	59
			7	—	47	41	69
Homewood Church Home	Washington	Church	8	—	—	52	12
Williamsport Sanatorium	Washington	Prop.	20	—	17	36	22
5 Nursing Homes	Washington	Prop.	—	40	98	113	161
			28	40	115	201	195
4 Nursing Homes	Wicomico	Prop.	—	—	80	59	61
			—	—	80	59	61
1 Nursing Home	Worcester	Prop.	—	—	5	5	11
			—	—	5	5	11

NPA—Non-Profit Association.
Prop.—Proprietary.

Table 3

NURSING HOME SUMMARY

November 1, 1955

POPULATION	RATIO ADOPTED BY STATE	TOTAL BEDS ALLOWED BY RATIO	TOTAL EXISTING BEDS	NET ADDITIONAL BEDS ALLOWED
2,522,000	1.5 Beds Per 1,000 Pop.	3,783	1,094	2,689

Existing and Proposed Facilities

AREAS	EXISTING BEDS	ADDITIONAL BEDS NEEDED TO PROVIDE 1.5 BEDS PER 1,000 POPULATION	TOTAL BEDS NEEDED
Allegany	—	136	136
Anne Arundel	43	161	204
Baltimore County-City	581	1,338	1,919
Calvert	—	19	19
Caroline	—	28	28
Carroll	26	45	71
Cecil	—	54	54
Charles	—	38	38
Dorchester	—	42	42
Frederick	26	70	96
Garrett	—	32	32
Harford	—	87	87
Howard	—	38	38
Kent	—	21	21
Montgomery	93	199	292
Prince George's	7	343	350
Queen Anne's	—	22	22
St. Mary's	—	51	51
Somerset	—	31	31
Talbot	—	30	30
Washington	68	56	124
Wicomico	—	62	62
Worcester	—	36	36
State Totals	844	2,939	3,783

Table 4

PRIORITY LISTING OF NURSING HOME AREAS

October 28, 1955

The Areas are listed in the order of number of beds needed per 1,000 population. Areas with the same ratio are arranged alphabetically, and would have equal priority.

AREAS	ADDITIONAL* BEDS NEEDED	BED-NEED PER 1,000 (UNMET)	% NEED MET	PRIORITY
Allegany	136	1.5	—	A
Calvert	19	1.5	—	A
Caroline	28	1.5	—	A
Cecil	54	1.5	—	A
Charles	38	1.5	—	A
Dorchester	42	1.5	—	A
Garrett	32	1.5	—	A
Harford	87	1.5	—	A
Howard	38	1.5	—	A
Kent	21	1.5	—	A
Prince George's	343	1.5	—	A
Queen Anne's	22	1.5	—	A
St. Mary's	51	1.5	—	A
Somerset	31	1.5	—	A
Talbot	30	1.5	—	A
Wicomico	62	1.5	—	A
Worcester	36	1.5	—	A
Anne Arundel	161	1.2	20	B
Frederick	70	1.1	26.7	B
Baltimore City-County	1,338	.89	30.3	B
Montgomery	199	1.0	31.8	B
Carroll	45	1.0	36.6	B
Washington	56	.67	54.5	C
State Total	2,939	1.0	22.3	

*These figures are the same as Column 2 of Table 3

CHAPTER IV

CHRONIC DISEASE HOSPITALS

Chronic Disease Hospitals, along with nursing homes, were discussed in the original Hospital Survey and Plan for the State of Maryland (1948) Chapter 8, page 86, titled, "Facilities for Chronic or Long-term Patients."

The policies expressed in the original Plan were as follows:

1. Chronic Disease hospital beds should be provided on a ratio of two beds per one thousand population.
2. They should be planned generally along the lines of the regional planning for general hospitals and, if possible, be located at regional centers.
3. They should be constructed as additions, or as close as practicable to general hospitals.
4. Nursing homes rendering services complementary to those of the chronic disease hospitals should be encouraged.
5. An integrated program should be set up for the coordination of the services of the general, mental, tuberculosis, and chronic disease hospitals, and nursing homes.

Policies 2, 3, 4, and 5 are still considered appropriate. The ratio of two chronic disease hospital beds per thousand population shown as Policy 1, was established as a minimum standard by the Public Health Service. The ultimate program for the construction of chronic disease hospital facilities in Maryland was based on this ratio. However, in the light of experience gained in this State in recent years, it is the opinion of this Committee that at this time planning should be limited to one bed per thousand population. When this standard has been attained, its adequacy should be studied before additional facilities are constructed.

Facilities for Chronically Ill in Maryland

The current inventory of chronic disease hospital beds is reported in Table 5. The data may be summarized as indicated below.

Institution	*Number of Hospitals*	*Number of Beds*	*Under Construction*	*Total*
Grand Total	12	1,743	409	2,152
State owned	3	436	409	845
Local Government				
Baltimore City	1	480		480
County	1	96		96
Others	7	731		731

Eleven institutions classified as chronic disease hospitals now serve the population of Maryland. One new unit is under construction at Hagerstown. These facilities have 1,743 beds in service. In addition, there is now under construction a total of 409 beds. Upon completion of construction, there will be available a total of 2,152 beds in nine chronic disease hospitals.

With the exception of the District of Columbia regional area, all other areas will have at least one chronic disease hospital located therein.

Recommended Plan for Construction

A standard of one chronic disease hospital bed per thousand population should be the immediate objective of the State program for the construction of chronic disease hospital facilities based on a population of 2,522,000. Having in mind that current facilities and current construction provide for 2,152 beds, there is thus an immediate requirement to build 370 additional chronic disease beds. The first priority for further construction should be assigned to a 180-bed addition to the Montebello State Hospital, as recommended by the Roberts' Subcommittee of the Committee on Medical Care of the State Planning Commission. The justification for this proposal, which appears in the Roberts' report, is as follows:

> There is no doubt that the 500 beds proposed for the Montebello State Hospital will be needed. Census figures disclose that in the 10-year period (1940-1950), persons in Maryland over 65 years of age increased 32%, from 123,500 to 163,500. It is estimated that in the next decade (1950-1960), the number in this age group will have increased to 239,000. The 1960 estimated figure is almost double that of the 1940. These figures correspond closely to the increasing number of older people throughout the country. The average life expectancy has been increasing year by year and the most recent figure, according to the U. S. Public Health Service, is that the average span of life is now 69.3. Since the incidence of disabling chronic illnesses is much higher among the older groups, it is definite that the number of beds required for their care would continue to increase during the years ahead.
>
> Having the 180-bed addition attached to the hospital rather than as detached units, permits efficient and economic operation and allows flexibility of the movement of patients according to the classification of their medical and nursing needs.
>
> In this connection, it should be emphasized that the Montebello State Hospital, because of its geographical location and its proximity to teaching institutions, will probably develop medically into broader programs of rehabilitation, teaching and research. Physical medicine and rehabilitation will be one of the main objectives in the medical programs of chronic hospitals. The State Health Department in its administration of the chronic hospitals in Maryland recognizes this and the program at Montebello is centered around the rehabilitation program. It is this Committee's pleasure in seeing this emphasis on rehabilitation. The need for flexibility within the chronic hospital and the importance of the movement of patients in accordance with the degree of medical and nursing requirements, highlights the need for the 500 beds at the Montebello State Hospital. It is obvious that some chronically ill people, particularly in the older age group, will not be rehabilitated. However, it has been established that people afflicted with certain paralytic illnesses (cerebral accidents, spinal cord injuries, Parkinson's disease, multiple sclerosis, etc.), when given rehabilitative therapy in the early stages of their illnesses, respond more readily than when these treatments are given at later periods. It is only human and medically wise that persons afflicted with an incapacitating illness be given physical therapy, when

indicated, even though, in a given case, the gains may be very limited. If, in the course of rehabilitative treatment, a patient becomes a little more physically independent, the efforts are worth-while. For this reason alone, the bed capacity of Montebello State Hospital should be increased to permit admission of patients in the early stages of chronic illness, when they can benefit most from the rehabilitation services.

Second priority should be assigned to such expansion of the chronic disease hospital beds in this State as may be planned and requested by the voluntary general hospital. Funds under the Wolverton Act should be made available to encourage such expansion.

In view of the unmet need for additional chronic disease beds as estimated under the most conservative criterion of need, one bed per one thousand population, and in view of the certainty of a substantial increase in the total population, and particularly in the number of the aged, it would appear that the District of Columbia area, comprised of Montgomery, Prince George's, St. Mary's, Charles, and Calvert Counties, is the most likely place for the construction of an additional chronic disease hospital. A study of the current need for chronic disease hospital care in this area and an estimate of the need, say in 1960, should be made in the near future and recommendations based on this study incorporated into subsequent revisions of this Plan.

Table 5

ACCEPTABLE AND NON-ACCEPTABLE CHRONIC DISEASE HOSPITALS

July 1, 1955

Name of Facility	Areas	Control	Type	Bed Capacity		No. Of Bassinets	Per Cent Occupancy	Number Of	
				Acceptable	Non-Acceptable			Patient Days	Patients Admitted
Children's Hospital School	Baltimore	NPA	CD	120	—	—	80.3	35,183	542
Happy Hills Convalescent Home for Children	Baltimore	NPA	CD	79	—	—	79.0	22,588	168
Home for Incurables of Baltimore City	Baltimore	NPA	CD	185	—	—	91.5	61,742	57
Baltimore City Hospitals—A & D	Baltimore	City	CD	480	—	—	52.5	139,888	963
Jenkins Memorial Hospital	Baltimore	NPA	CD	90	—	—	99.5	32,716	30
James Lawrence Keroan Hospital	Baltimore	NPA	SP	85	—	—	74.6	23,129	501
Levindale Hebrew Home	Baltimore	NPA	CD	120	—	—	102.0	44,996	67
Montebello State Hospital	Baltimore	State	CD	365	—	—	30.2	40,247	188
Allegany County Infirmary	Allegany . . . . . Cumberland	County	CD	96	—	—	97.6	34,310	47
Christ Child Farm for Convalescent Children	Montgomery . . Rockville	Church	CD	52	—	—	49.0	9,181	80
Deer's Head State Hospital	Wicomico . . . . Salisbury	State	CD	284	—	—	96.9	100,493	142
Western Maryland State Hospital	Washington . . . Hagerstown	State	CD	196	—	—	—	—	—
State Total				2,152					

NPA —Non-Profit Association.
CD —Chronic Disease.
SP —Special Hospital.

CHAPTER V

REHABILITATION CENTERS

Chapter 8 of the original Hospital Survey and Plan for the State of Maryland, entitled "Facilities for Chronic and Long-Term Patients" contains the following statement:

> . . . With newer techniques, some chronic conditions which were formerly considered permanent and incurable are now considered curable or controllable with prospects of the patient being returned to society on a rehabilitated basis, adjusted to the residual disability or limitations imposed by the disease. Many chronic patients, therefore, are looked upon today as being in the process of a long convalescence.

The statement quoted was written in 1947, following the close of World War II and before war experience in rehabilitation services had become a part of the programs for the general population. Through the intervening years, science has continued to make phenomenal progress in combating disease with the result that the population in the higher age groups and the number of people who have survived serious illness with varying degrees of disability has continued to grow. High speed in industry and travel is adding to this number even in the younger age groups.

Concurrently, progress has been made in the field of rehabilitation. However, the potential benefits of active rehabilitation have not been realized due to a dearth of facilities and specially trained personnel.

The object of rehabilitation service is to restore the patient to the maximum degree of physical and social independence. Many patients who were formerly considered to be totally or permanently disabled, now, through rehabilitation services of various types, can become ambulatory, physically independent to varying degrees, and in some cases self-supporting.

The direct patient benefits from a rehabilitation program are a more satisfactory life, with less dependence on others. In many cases it means the difference between a permanent bedridden status in the home or an institution or an ambulatory status outside of an institution. Effective rehabilitation services, therefore, can have an important effect on the number of institutional beds needed.

Rehabilitation service is a part of any program which is intended to return a person to normal living. It includes such simple procedures as teaching a patient to feed himself, or to use the toilet. It includes teaching a person to use an artificial limb or a hearing aid. It becomes more complicated in cases such as spinal cord injuries where muscle reeducation is required and the whole life pattern must be revised, including training for a new vocation.

Such complex programs require a team approach by specialists in several fields. Under the Public Health Service definition, an integrated rehabilitation program includes medical, psychological, social, and vocational evaluation and services under competent professional supervision.

Broad programs, including the services of the various professional skills have been established as autonomous institutions, including nursing units for bed patients, while others have been set up as adjuncts of hospitals.

In view of the dearth of professional personnel in the various fields, it is the opinion of this Committee that initially rehabilitation facilities should be established in conjunction with teaching programs so that necessary professional personnel might be produced. While unaffiliated or independent rehabilitation centers might be established with difficulty today, it is felt that in future years, after teaching programs have produced adequate numbers of specially trained personnel, they might be established with less difficulty.

In some instances rehabilitation services in specialized fields have been established. It is felt that such specialized facilities serving a limited group are important, however, they should be assigned a lower priority than applicants with a project for the establishment of a comprehensive service.

The Wolverton Amendment authorized Congress to appropriate funds for the specific purpose of encouraging the construction of rehabilitation facilities.

Inventory of Existing Facilities

The inventory was conducted by the Division of Vocational Rehabilitation of the State Department of Education. Data were obtained from all pertinent sources, and it is evident therefrom that although numerous *splinter* facilities exist in Maryland, providing services of special rather than multiple character, or services of less than community scope, there is no facility known which qualifies in all respects as an *existing rehabilitation facility* meeting the program definition.

Table 6 lists the existing facilities. Where such a facility is housed in a suitable physical plant and is providing a community service, it will be considered as partly meeting the State's unmet need. Where a facility is providing a community service in a plant of unsafe construction (*unsuitable*) or in an obsolete or inadequate plant (*replaceable*), it is considered as partly meeting the need as a facility only if noted *replaceable*.

Program of Distribution and Priority

Using the Public Health Service minimum standard of one facility, single or multiple, per each 300 000 unit of population, and the established estimated State population of 2,522,000, the State is allowed a total of 8 rehabilitation facilities. It is not expected that this extent of construction will be reached in the foreseeable future.

Although distribution will depend chiefly upon the description and location of prospective applications, every effort will be made to meet the intent of the

authors of the program, with which the responsible authorities in Maryland are in agreement.

Priority will accordingly be given to applications in the following order:

1. Projects connected with established medical teaching institutions. There are two of these, both in Baltimore. A facility affiliated with either or both would meet the intent of the program and help to overcome the deficiency both in facilities and in trained personnel.
2. Projects affiliated with general hospitals of over 200 beds. One such hospital exists in each of the five State regions, either as established in the original State Plan, or as modified in the program for chronic disease hospitals.
3. Projects which would produce a rehabilitation facility offering a comprehensive service.
4. Applications for projects to be affiliated with other hospitals of 50 beds or more.
5. Projects which would offer services in a special area of need.

The need for rehabilitation services is now urgently felt by all of our population. It is the considered view of this Committee that a project which falls within category (1) above and deserving highest priority would be the further development of the rehabilitation facilities of the Montebello Chronic Disease Hospital in Baltimore City. This hospital is the central unit of the State Chronic Disease Hospital system; it has a close working relationship with the two teaching institutions, University of Maryland and Johns Hopkins Medical School; it already has a rehabilitation program with limited facilities in use and additional facilities under construction. In order to develop these facilities further, it will be necessary to expand present construction which is limited in the planned scope of services to be rendered and in the volume of patients which can be accommodated.

Applications which are received for projects which will offer services for single disabilities will be given due consideration, in the absence of applications having a broader scope of program.

Table 6

INVENTORY OF REHABILITATION FACILITIES

November 3, 1955

CLASSIFICATION CODE

S — Suitable
R — Replaceable
U — Unsuitable

SERVICES CODE

Medical

A — Physical and Medical Evaluation
B — Medical Supervision
C — Physical Therapy
D — Occupational Therapy
E — Speech Therapy
F — Audiological Services (including lip reading)
G — Prosthetics Brace Fit
H — Psychiatric
I — Dental
J — Nursing
K — Physical Education
L — Medical Consultation
M — Recreational Therapy

Psychological

N — Evaluation

Social

O — Evaluation
P — Social Casework
Q — Social Groupwork
R — Recreation (non-medical)

Vocational

S — Evaluation
T — Vocational Counseling
U — Pre-vocational Experiences
V — Special Education
W — Vocational Training
Y — Sheltered Employment
Z — Travel Training for Blind

Name of Facility	City or Town	Classification	Ownership or Control (Code)	Average Daily Caseload		Number of Individuals Served During Year	Age Groups Served		Groups Served							Services (Code)			
				Inpatient	Outpatient		Under 16	Over 16	Deaf	Blind	Tuberculosis	Cardiac	Orthopedic	Neurological	Other	Medical	Psychological	Social	Vocational
ALLEGANY COUNTY																			
Memorial Hospital	Cumberland	S	City	208.1	41	25,047	X	X	X	X	X	X	X	X		A,B,C,J,*	N		
Miners Hospital	Frostburg	R	State	28	—	1,322	X	X				X	X	X		A,B,J,L			
Sacred Heart Hospital	Cumberland	S	Church	112	11	8,690	X	X				X	X	X		A,B,C,J,L			
ANNE ARUNDEL COUNTY																			
Anne Arundel General Hospital	Annapolis	S	NPA	12.6	24.7	13,643	X	X					X			A,B,J,L			
Crownsville State Hospital	Crownsville	S	State	2,569	—	3,074	X	X	X	X	X	X	X	X		A,B,C,D,J,L,M	N,*	O,P,Q,R	U,Y,*
BALTIMORE CITY — COUNTY																			
Baltimore City Hospitals (All Divisions)	Baltimore	S	City	1,253	278	85,817	X	X			X	X	X	X	X	A,B,D,G,H,J,L		P,R,*	S,T,U,V,W,*
Baltimore Eye, Ear, and Throat Hospital	Baltimore	S	NPA	44	50	26,547	X	X	X	X						A,F,G,J,L		P	
Baltimore Goodwill Industries	Baltimore	U	NPA		163	336		X	X	X	X	X	X	X			*	O,P,R	S,T,U,W,Y,*
Baltimore Hearing Society, Inc.	Baltimore	U	NPA	—	21	7,601	X	X	X							E,F,G,M,*		Q,R	
Baltimore League for Crippled Children and Adults	Baltimore	U	NPA		40	75	X			X	X	X	X	X				P,R	W,Y
Bon Secours Hospital	Baltimore	S	Church	145	25	22,238	X	X				X	X	X		A,B,C,H,J,L			
Children's Hospital School, Inc.	Baltimore	S	NPA	97	5	2,455	X	X					X	X	X	A,B,C,D,J,L,M			
Children's Rehabilitation Institute for Cerebral Palsy, Inc.	Reisterstown	S	NPA	46	—	73	X							X		A,B,C,D,E,F,G,J,L,*	N,*	R,*	*
Church Home and Hospital	Baltimore	S	NPA	144	23.4	12,824	X	X			X	X	X			A,L,*		O,P	
Eudowood Sanatorium (Hospital for Consumptives of Md.)	Towson	R	NPA	104	.4	418	X	X			X					A,B,J,L		P,Q,R	T,Y
Hearing and Speech Center (Johns Hopkins Hospital)	Baltimore	S	NPA		11	3,969	X	X	X					X	X	A,B,E,F,G		*	

*Other services not categorized.
NPA—Non-Profit Association.

Table 6 (Continued)

INVENTORY OF REHABILITATION FACILITIES

November 3, 1955

Name of Facility	City or Town	Classification	Ownership or Control (Code)	Average Daily Caseload		Number of Individuals Served During Year	Age Groups Served		Groups Served							Services (Code)			
				Inpatient	Outpatient		Under 16	Over 16	Deaf	Blind	Tuberculosis	Cardiac	Orthopedic	Neurological	Other	Medical	Psychological	Social	Vocational
BALTIMORE CITY — COUNTY (cont'd)																			
Heart Association of Md.	Baltimore	S	NPA	—	.3	120	X	X				X				A,B,D,L,M,*		O,P,R	
Hospital for the Women of Maryland	Baltimore	S	NPA	18	64.6	23,373	X	X				X	X	X		A,B,H,J,L			
James Lawrence Kernan Hospital and Industrial School of Maryland for Crippled Children, Inc.	Baltimore	S	NPA	63	—	566	X						X	X	X	A,B,C,D,J,L,M			
Johns Hopkins Hospital	Baltimore	S	Corporation	772	1,338	401,510	X	X	X	X	X	X	X	X		A,B,C,D,E,G,H,J,K,L,M	N	O,P	Y
Lutheran Hospital of Md.	Baltimore	S	NPA	180.2	68	34,757	X	X			X	X	X	X	X	A,B,C,H,J,L,M	N	O,P	
Maryland General Hospital	Baltimore	S	NPA	196	7.9	8,909	X	X				X	X			A,B,J,K,L			
Maryland School for the Blind	Baltimore	S	NPA	170	4	174	X	X	X	X						D,E,F,J,M	N,*	O,R	S,T,U,V,W,Z,*
Mercy Hospital, Inc.	Baltimore	R	Church	254	102	36,435	X	X			X	X	X	X		A,B,C,H,J,L			
Montebello State Hospital	Baltimore	S	State	56	—	77		X				X	X	X	X	A,B,C,D,E,G,H,J,L,M	N		S,T,V,*
Mount Pleasant, Inc.	Baltimore	S	Partnership	51	—	87		X			X					A,B,D,H,J,L,M	*	O,P,R,*	S,T,W,*
Mt. Wilson State Hospital	Mt. Wilson	S	State	365		704	X	X			X				X	A,B,D,H,J,L	N,*	O,P,R,*	S,T,U,V,W,Y,*
Presbyterian Eye, Ear and Throat Charity Hospital	Baltimore	S	Church	11	21	4,766	X	X							X	A,B,F,J,L		O	
Provident Hospital	Baltimore	U	NPA	110.3	66	8,227	X	X				X	X	X		A,B,J,L			
Rosewood State Training School	Owings Mills	S	State	1,657		1,789	X		X	X	X	X	X	X	X	A,B,D,E,F,G,H,J,L,M	N,*	O,P,Q,R	U,V,Y,*
St. Agnes Hospital	Baltimore	S	Church	187	15	10,196	X	X				X	X	X		A,B,J,L			
St. Joseph's Hospital	Baltimore	R	Church	187	45	21,638	X	X				X	X	X		A,B,C,J,L		O,P	
Sinai Hospital of Baltimore, Inc.	Baltimore	S	Corporation	303	—	75,171	X	X								A,B,C,D,E,H,J,L		O,P	
South Baltimore General Hospital	Baltimore	S	NPA	140	50	36,000	X	X								A,B,C,G,J,K,L	*	O,P	
Spring Grove State Hospital	Catonsville	S	State	2,807	—	3,437		X	X	X		X	X	X		A,B,C,D,H,J,L,M	N,*	O,P,Q,R	U,Y,*
Tuberculosis Division Baltimore City Hospitals	Baltimore	S	City	280	—	680		X			X				X	A,B,C,D,H,J,L,M	*	O,P,Q,*	S,T,U,V,W,*
Union Memorial Hospital	Baltimore	S	NPA	275	80	41,945	X	X				X	X	X	X	A,B,C,J,L		O,P	
University Hospital, of the University of Maryland	Baltimore	S	State	458	381	29,747	X	X			X	X	X	X		A,B,C,D,H,J,K,L,M	N,*	O,P,Q	

*Other services not categorized.
NPA—Non-Profit Association.

Table 6 (Continued)

INVENTORY OF REHABILITATION FACILITIES

November 3, 1955

Name of Facility	City or Town	Classification	Ownership or Control (Code)	Average Daily Caseload		Number of Individuals Served Dur. Ng Year	Age Groups Served		Groups Served							Services (Code)			
				Inpatient	Outpatient		Under 16	Over 16	Deaf	Blind	Tuberculosis	Cardiac	Orthopedic	Neurological	Other	Medical	Psychological	Social	Vocational
CALVERT COUNTY																			
Calvert County Hospital	Prince Frederick	S	Corporation	23	1.6	2,053	X	X											
CARROLL COUNTY																			
Henryton State Hospital	Henryton	S	State	411	—	809	X	X			X				X	A,B,G,H,J,L	N,*	O,P,R,*	S,T,U,V,W,Y,*
Springfield State Hospital	Sykesville	S	State	3,430		4,132		X	X	X	X	X	X	X	X	A,B,C,D,H,J,L,M	N,*	O,P,Q,R	U,V,*
CECIL COUNTY																			
Union Hospital of Cecil County	Elkton	S	NPA	42	42	3,957	X	X								J,L			
DORCHESTER COUNTY																			
Cambridge Maryland Hospital, Inc.	Cambridge	U	NPA	40	10	3,779	X	X			X	X	X	X	X	A,B,C,G,J,K,L			
Eastern Shore State Hospital	Cambridge	S	State	618		723		X	X	X		X	X	X		A,B,D,H,J,L,M	N,*	O,P,Q,R	U,Y,*
FREDERICK COUNTY																			
Frederick Memorial Hospital	Frederick	S	NPA	116	14.4	11,570	X	X								J,L			
Maryland State School for the Deaf	Frederick	U	State	140 (Pupils)	—	140	X	—	X							A,F,J,M,*	*	R	U
Victor Cullen State Hospital	Cullen	S and U	State	317	—	606	—	X			X				X	A,B,H,J,L	*	O,P,R,*	S,T,U,W,Y,*
GARRETT COUNTY																			
Garrett County Memorial Hospital	Oakland	S	County	37	2	2,885	X	X				X	X			A,B,C,J,L	N		
KENT COUNTY																			
Kent and Queen Anne's Hospital	Chestertown	R	NPA	—	—	—	X	X								A,B,J,L			
MONTGOMERY COUNTY																			
Treatment Center for Crippled Children and Adults	Rockville	U	NPA	—	8	233	X	X					X	X		C,E,M	N		
PRINCE GEORGE'S COUNTY																			
Eugene Leland Memorial Hospital	Riverdale	S	NPA	35.3	49	19,725	X	X				X	X			A,B,C,J,L			
SOMERSET COUNTY																			
Edward W. McCready Memorial Hospital	Crisfield	R	NPA	21	21	2,506	X	X								A,B,J			
TALBOT COUNTY																			
Memorial Hospital at Easton, Maryland, Inc.	Easton	S	NPA	95	19	12,243	X	X					X	X		A,B,C,J,L			
WASHINGTON COUNTY																			
Washington County Hospital	Hagerstown	S	NPA	12	23	4,680	X	X					X	X		A,B,C,J,L			
WICOMICO COUNTY																			
Deer's Head State Hospital	Salisbury	S	State	44	—	78**	—	X				X	X	X	X	A,B,C,G,H,J,L,M		P	S,T,V *
Peninsula General Hospital	Salisbury	S	NPA	30	30	19,374	X	X								A,B,J			
Pine Bluff State Hospital	Salisbury	S	State	56.5	.01	120	—	X			X					A,B,J,L		R	

*Other services not categorized.
NPA—Non-Profit Association.
**In operation 6 months.

Table 7

REHABILITATION FACILITIES SUMMARY

February 1956

Population 2,522,000	Total Facilities Allowed by the State Ratio for Each Type of Disability: 8

Additional Facilities Proposed:

Community	*Description of Facilities and Services to be Provided*
Baltimore City	An integrated facility at the Montebello State Hospital, occupying the first floor of a proposed 180-bed addition to the Chronic Disease facility now under construction. The proposed facility will comprise a gross space about 86′ x 180′ and provide the following: Waiting Room 25′ x 35′ Evaluation Room 23′ x 33′ Occup. Therapy 50′ x 90′ Hydro- and Phys. Therapy 27′ x 50′ Exercise 34′ x 58′ Thermo. Therapy 23′ x 23′ Speech Therapy 23′ x 23′ Activities of Daily Living 23′ x 47′ Plus related offices, Examining Rooms, Toilets, Storerooms, etc. The project under construction provides the above features to an extent commensurate with a 500-bed Chronic Disease hospital. Several applications are pending for partial-service projects and will be summarized in the first annual revision.

CHAPTER VI

DIAGNOSTIC AND TREATMENT CENTERS

Definition

A Diagnostic and Treatment Center is a facility in which diagnostic services only, or diagnostic and treatment services are provided primarily for ambulatory patients. Such facilities when established as parts of hospitals are known as *outpatient departments*. When established as separate, self-contained entities, they are commonly referred to as *clinics*. Outpatient departments and independent clinics in a strict sense are intended to supply diagnostic and/or treatment services which are beyond the scope of the general practitioner for patients who do not necessarily need to occupy a bed in a hospital. This basic concept is frequently modified for economic and social reasons or educational purposes.

Origin and Function of Diagnostic and Treatment Centers

Hospitals affiliated with medical schools initially planned outpatient departments for the purpose of providing clinical and research material and experience for medical students. Because of the dedicated purpose of such programs patients are not usually limited to those whose needs cannot be met in a physician's office. The only eligibility requirement may be that the patient's income be below established levels.

Most hospitals other than those affiliated with medical schools were established for the single purpose of supplying inpatient care with no initial plans for outpatient services. Demand for service beyond the scope of the physician's office but not requiring overnight stay in the hospital forced most hospitals to provide outpatient services. The scope of such services varies from the mere scheduling of hours, when services are available, to highly organized departments including scheduled clinics in many special fields, and also screening or steering clinics.

Independent clinics parallel in scope to the outpatient departments of hospitals came into being on a somewhat different basis. Government or voluntary agencies established diagnostic and/or treatment clinics in special fields. In some cases groups interested in a single health problem established clinic services in the specialty of interest to them. Physicians, individually or in groups, established clinics or group practices, for the purpose of offering their patients a broader scope of service. Industries established clinics for the medical care of their employees and in some instances their families.

In communities, situated at a considerable distance from hospitals, which cannot support a hospital, community clinics may be established for the purpose of providing diagnostic and treatment facilities. They may, in addition, serve as the focal point of the coordinated activities of medical groups including physicians, general and para-medical personnel, both local and visiting.

It is generally recognized that there is a need for diagnostic and treatment services for ambulatory patients. Justification for this program of facilities and service is based on the belief that it will:

1. Supplement the work of doctors' offices.
2. Foster preventive medicine through case-finding.
3. Keep beds free in general hospitals.
   (a) Provide community service without requiring the patient to occupy a bed.
   (b) Promote earlier discharge of inpatients.

Federal Participation

Outpatient departments of hospitals which meet State and Federal criteria are eligible for allocation of Federal funds under the original Hill-Burton Program. The Wolverton Amendment established them as a separate category of facilities and authorized the appropriation of Federal funds for their construction. This makes possible the allocation of Federal funds under the Hill-Burton Program or the Wolverton Amendment to projects for construction of outpatient departments as parts of hospitals. Wolverton funds may also be allocated to projects for the construction of such facilities as separate entities independent of hospitals.

Inventory

In developing a construction program in this category the Committee has followed the procedure established by the Public Health Service. Pertinent inventory data was collected from organized outpatient clinics, and from hospitals serving ambulant patients significantly without organized outpatient departments; from public and nonprofit clinics offering diagnostic and treatment services of psychiatric, cancer, crippled children, heart, dental and tuberculosis nature; from nonprofit dispensaries or clinics without hospital association; from public health centers and laboratories offering appropriate services. Data was not obtained from private, Federal, or industrial dispensaries, and other comparable sources for the reason that they do not render a community service as defined in this program. However, when applications are considered for the purpose of establishing priorities, the extent to which the communities' needs are met by such facilities will be taken into account in order to determine the net unmet need for diagnostic and treatment services.

Since this category of facilities is intended to supply service to ambulatory patients, when approving projects under this category, emphasis should be placed on outpatient service to the community rather than on providing added or improved facilities for inpatient hospital care.

Table 9, SUITABLE AND UNSUITABLE DIAGNOSTIC AND TREATMENT CENTERS, shows the inventory and information indicated.

Diagnostic and Treatment Centers

A suitable facility is one providing or capable of providing a significant amount of community service, if housed in satisfactory quarters on the ground floor in fire-resistive construction, or in approved sprinkler-protected ordinary construction.

A replaceable facility is one actually providing a significant amount of service in inadequate or inefficient or poorly located quarters in which construction is not hazardous.

An unsuitable facility is one providing basic or greater services to a significant extent but in hazardous quarters, or in quarters having drawbacks in two or more of the categories which determine a replaceable facility.

Where the survey developed that a physically suitable facility exists, the schedule counts it as such, even though its current utilization may be of questionable significance, in order to obviate duplication.

Table 8, DIAGNOSTIC OR TREATMENT CENTER SUMMARY, summarizes the facilities inventoried in Table 9, the additional facilities allowed, and other significant data intended to develop the State Plan in this category.

Table 10, RELATIVE NEED REPORT, establishes the priorities of the counties and Baltimore City on the basis of relative need.

The findings of the survey demonstrated that generally utilization of diagnostic and treatment facilities varies directly with population density. On the basis of these findings it was concluded that the ratio of facilities to population should be lower in areas with higher population density. To implement this conclusion, the following standards were established.

Population of Area	*Ratio of Diagnostic and Treatment Centers to Population*
Under- 25,000	1: 10,000
25,000-100,000	1: 20,000
100,000-250,000	1: 30,000
Over-250,000	1: 40,000

These ratios should be reviewed at the time of annual revision of this Plan for the purpose of adjustment, if they are found to be unrealistic.

Allowances on the basis of the above standards are stated in the column headed, "Quota", Table 10. In the case of Calvert County the quota was arbitrarily increased since it is considered that each county should have the opportunity to provide a suitable health center, regardless of existing facilities in or connected with hospitals.

The percentage of need met was computed by relating the existing acceptable facilities to the quota. The areas were then arranged in the ascending order of percent of met need, thus giving top priority to the areas with the lowest percent of their needs met.

Table 8

DIAGNOSTIC AND TREATMENT CENTERS SUMMARY

January 1956

Population	Total Centers Allowed by State Ratio	Total Existing Centers	Net Additional Centers Allowed
2,522,000	94*	64	42*

Community	No. of Existing Centers		Diagnostic Services				Diagnostic or Diagnostic and Treatment Services						
			X-Ray		Clinical Laboratory		General	Cancer	Dental	Mental Hygiene	Ortho-pedic	T.B.	Other
	E	P	E	P	E	P							
Allegany County	5	—	4	—	4	—	2	—	2	1	3	1	3
Anne Arundel County	2	1	2	—	2	—	1	1	1	1	2	1	1
Baltimore City	25	2	21	2	C	2	17	6	11	4	9	10	21
Baltimore County	1	—	1	—	C	—	—	3	Schools	5	—	11	10
Calvert County	1	—	2	—	1	—	1	1	—	1	1	1	1
Caroline County	1	—	1	—	—	—	—	1	—	1	1	1	1
Carroll County	1	—	1	—	—	—	—	1	—	1	1	1	1
Cecil County	1	—	2	—	2	—	—	1	—	1	1	1	1
Charles County	1	—	2	—	2	—	1	1	1	1	1	1	1
Dorchester County	2	—	2	—	2	—	1	1	—	1	2	1	2
Frederick County	2	—	2	—	2	—	1	1	1	1	1	1	1
Garrett County	2	—	2	—	1	—	1	—	—	—	1	1	1
Harford County	2	—	2	—	1	—	1	1	1	1	1	1	1
Howard County	—	—	1	—	—	—	—	1	—	1	1	1	1
Kent County	2	—	2	—	1	—	1	1	—	1	1	1	1
Montgomery County	1	1	4	—	4	—	3	1	1	2	3	1	3
Prince George's County	2	—	3	—	2	—	2	3	—	1	2	1	2
Queen Anne's County	0	—	1	—	—	—	—	1	—	1	1	1	1
St. Mary's County	2	—	2	—	1	—	1	1	—	1	1	1	1
Somerset County	2	—	2	—	1	—	1	1	—	1	1	1	1
Talbot County	2	—	2	—	2	—	1	1	—	1	2	1	1
Washington County	2	—	2	—	2	—	1	1	1	1	1	1	1
Wicomico County	2	—	2	—	2	—	1	1	1	1	1	1	1
Worcester County	—	—	1	—	—	—	—	1	—	—	1	1	1
State Total	64												

* Kent County has quota plus 1.
C —Central Laboratory.
E —Existing.
P —Proposed.

Table 9

INVENTORY OF DIAGNOSTIC AND TREATMENT CENTERS

September 1, 1955

NAME OF FACILITY	CITY OR TOWN	OWNERSHIP OR CONTROL	VISITS DURING YEAR	SERVICES							DIAGNOS. SERVICES		HOSPITAL OPD	CLASSIFICATION		
					SPECIAL											
				General	Cancer	Dental	Mental Hygiene	Orthopedic	T.B.	Other	X-ray	Clinical Laboratory		Suitable	Replaceable	Unsuitable
ALLEGANY COUNTY																
Sacred Heart Hospital	Cumberland	Church	7,328	X	—	—	—	X	—	X	X	X	X	X	—	—
Memorial Hospital	"	City	15,053	X	—	X	—	X	—	X	X	X	X	X	—	—
Miners Hospital	Frostburg	State	768	—	—	—	—	—	—	—	X	X	—	X	—	—
Reeves Clinic (Closed)	Westernport	Partnership	—	—	—	—	—	—	—	—	—	—	—	—	—	—
County Health Department		County	7,253	—	—	X	X	X	X	X	X	X	—	—	X	—
ANNE ARUNDEL COUNTY																
Anne Arundel General Hospital	Annapolis	NPA	9,000	X	—	—	—	X	—	—	X	X	X	X	—	—
County Health Department	"	County	13,293	—	X	X	X	X	X	X	X	X	—	X	—	—
BALTIMORE CITY																
Baltimore City Hospital	Baltimore	City	69,380	X	—	—	—	—	X	X	X	X	X	X	—	—
Bon Secours Hospital	"	Church	20,546	X	—	—	—	—	—	—	X	X	X	X	—	—
Church Home and Hospital	"	NPA	5,797	X	—	—	—	—	—	X	X	X	X	—	X	—
Doctors Hospital	"	NPA	199	X	—	—	—	—	—	X	X	X	—	—	—	X
Franklin Square Hospital	"	NPA	20,000	X	—	—	—	—	X	X	X	X	X	X	—	—
Hospital for Women of Maryland	"	NPA	16,787	X	—	—	—	—	—	—	X	X	X	X	—	—
Johns Hopkins Hospital	"	NPA	374,696	X	X	X	X	X	X	X	X	X	X	X	—	—
Lutheran Hospital of Maryland	"	NPA	24,000	X	—	X	—	X	—	X	X	X	X	—	X	—
Maryland General Hospital	"	Church	6,640	X	—	—	—	X	—	X	X	X	X	X	—	—
Mercy Hospital	"	Church	40,300	X	—	—	—	—	—	X	X	X	X	—	X	—
Provident Hospital and Free Dispensary	"	NPA	32,842	X	X	X	—	X	—	X	X	X	X	—	X	—
St. Agnes Hospital	"	Church	14,996	X	—	X	—	—	—	X	X	X	X	—	X	—
St. Joseph's Hospital	"	Church	27,387	X	X	X	—	X	—	X	X	X	X	—	X	—
Sinai Hospital of Baltimore	"	NPA	60,797	X	X	X	X	X	X	X	X	X	X	X	—	—
South Baltimore General	"	NPA	24,597	X	—	—	—	—	—	—	X	X	X	X	—	—
Union Memorial Hospital	"	NPA	30,073	X	—	—	—	X	—	X	X	X	X	X	—	—
University Hospital	"	State	107,870	X	X	X	X	X	X	X	X	X	X	X	—	—
City Health Department (8 Stations)	"	City	151,715	—	—	X	—	—	X	X	X	—	—	4	—	4
BALTIMORE COUNTY																
County Health Department (11 Stations)	Towson (Hq)	County	13,203	—	X	X	X	X	X	X	X	—	—	2	4	5
CALVERT COUNTY																
Calvert County Hospital	Prince Frederick	NPA	590	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	1,940	—	X	—	X	X	X	X	X	—	—	—	—	X
CAROLINE COUNTY																
County Health Department	Denton	County	714	—	X	—	X	X	X	X	X	—	—	X	—	—
CARROLL COUNTY																
County Health Department	Westminster	County	1,170	—	X	—	X	X	X	X	X	—	—	X	—	—
CECIL COUNTY																
Union Hospital	Elkton	NPA	1,569	—	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	2,000	—	X	—	X	X	X	X	X	X	—	—	—	X
CHARLES COUNTY																
Physicians' Memorial Hospital	La Plata	County	2,500	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	2,305	—	X	X	X	X	X	X	X	X	—	—	—	X
DORCHESTER COUNTY																
Cambridge Maryland Hospital	Cambridge	NPA	2,120	X	—	—	—	X	—	X	X	X	—	—	X	—
County Health Department	"	County	2,333	—	X	—	X	X	X	X	X	X	—	—	X	—

NPA — Non-Profit Association.

Table 9 (Continued)

INVENTORY OF DIAGNOSTIC AND TREATMENT CENTERS

September 1, 1955

Name of Facility	City or Town	Ownership or Control	Visits During Year	Services							Diagnos. Services		Hospital OPD	Classification		
				General	Special											
					Cancer	Dental	Mental Hygiene	Orthopedic	T.B.	Other	X-ray	Clinical Laboratory		Suitable	Replaceable	Unsuitable
REDERICK COUNTY																
Frederick Memorial Hospital	Frederick	NPA	5,257	X	—	—	—	—	—	—	X	X	—	X		—
County Health Department	"	County	3,567	—	X	X	X	X	X	X	X	X	—	—	—	X
ARRETT COUNTY																
Garrett County Memorial Hospital	Oakland	County	1,537	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	1,295	—	—	—	—	X	X	X	X	—	—	X	—	—
ARFORD COUNTY																
Harford Memorial Hospital	Havre de Grace	NPA	1,793	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	3,776	—	X	X	X	X	X	X	X	—	—	X	—	—
OWARD COUNTY																
County Health Department	Ellicott City	County	1,056	—	X	—	X	X	X	X	X	—	—	—	—	X
ENT COUNTY																
Kent and Queen Anne's Hospital	Chestertown	NPA	1,263	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	1,564	—	X	—	X	X	X	X	X	—	—	X	—	—
IONTGOMERY COUNTY																
Montgomery County General Hospital	Olney	NPA	573	X	—	—	—	—	—	—	X	X	—	X	—	—
Suburban Hospital	Bethesda	NPA	9,491	X	—	—	—	X	—	X	X	X	X	X	—	—
Washington Sanatorium and Hospital	Tacoma Park	Church	56,066	X	—	—	X	X	—	X	X	X	X	X	—	—
County Health Department	Rockland	County	9,152	—	X	X	X	X	X	X	X	X	—	X	—	—
RINCE GEORGE'S COUNTY																
Eugene Leland Memorial Hospital	Riverdale	NPA	37,500	X	X	—	—	—	—	—	X	X	—	X	—	—
Prince George's General Hospital	Cheverly	County	21,566	X	X	—	—	X	—	X	X	X	X	X	—	—
County Health Department	Hyattsville	County	4,946	—	X	—	X	X	X	X	X	—	—	—	—	X
)UEEN ANNE'S COUNTY																
County Health Department	Centreville	County	1,084	—	X	—	X	X	X	X	X	—	—	—	—	X
T. MARY'S COUNTY																
St. Mary's Hospital	Leonardtown	NPA	1,621	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	1,907	—	X	—	X	X	X	X	X	—	—	X	—	—
OMERSET COUNTY																
Edward W. McCready Memorial Hospital	Crisfield	NPA	2,457	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	1,482	—	X	—	X	X	X	X	X	—	—	—	X	—
ALBOT COUNTY																
Easton Memorial Hospital	Easton	NPA	8,000	X	—	—	—	X	—	—	X	X	—	X	—	—
County Health Department	"	County	773	—	X	—	X	X	X	X	X	X	—	—	X	—
VASHINGTON COUNTY																
Washington County Hospital	Hagerstown	NPA	20,908	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	4,180	—	X	X	X	X	X	X	X	X	—	X	—	—
VICOMICO COUNTY																
Peninsula General Hospital	Salisbury	NPA	9,383	X	—	—	—	—	—	—	X	X	—	X	—	—
County Health Department	"	County	6,745	—	X	X	X	X	X	X	X	X	—	X	—	—
VORCESTER COUNTY																
County Health Department	Pocomoke	County	1,164	—	X	—	—	X	X	X	X	—	—	—	—	X

NPA — Non-Profit Association.

Table 10

DIAGNOSTIC AND TREATMENT FACILITIES
RELATIVE NEED REPORT

Areas	Population	Quota *	Existing		Deficiency	% Need Met	Priority
			Public Health	Hospitals			
Queen Anne's	14,761	1	—	—	1	0	
Worcester	23,850	2	—	—	2	0	A
Howard	25,350	2	—	—	2	0	(0 to 49% met)
Prince George's	233,637	8	1	1	6	25	
Frederick	64,248	3	—	1	2	33	
Anne Arundel	135,844	5	1	1	3	40	
Calvert	12,703 [1]	2	—	1	1	50	
Caroline	18,475	2	1	—	1	50	
Charles	25,593	2	—	1	1	50	
Cecil	35,959	2	—	1	1	50	B
Carroll	47,095	2	1	—	1	50	(50 to 90% met)
Washington	82,517	4	1	1	2	50	
Baltimore County	313,363	8	4	—	4	50	
Allegany	90,489	5	—	3	2	60	
Harford	57,815	3	1	1	1	67	
Montgomery	194,724	6	1	3	2	67	
Baltimore City	966,000	24	4	16	4	83	
Dorchester	27,865	2	1	1	—	100	
Kent	13,907	1	1	1	—	100	
Talbot	19,807	2	1	1	—	100	
Somerset	20,822	2	1	1	—	100	C
Garrett	21,250	2	1	1	—	100	(91 to 100% met)
St. Mary's	34,382	2	1	1	—	100	
Wicomico	41,544	2	1	1	—	100	
Totals	2,522,000	94	22	37	36	66	

* For population up to 25,000 ..... 1:10,000
" " between 25,000 and 100,000 ..... 1:20,000
" " " 100,000 and 250,000 ..... 1:30,000
" " over 250,000 ..... 1:40,000

Increase to allow for suitable Public Health Center.

Md.
309.1752
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